U. S. S E N A T E

Republican Policy Committee

Don Nickles, Chairman Doug Badger, Staff Director 347 Russell Senate Office Building (202)224-2946

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The National Governors' Association Medicaid Proposal

Today the National Governors' Association meeting of 48 governors overwhelmingly passed a proposal to overhaul the nation's Medicaid health system for low-income individuals. Both Majority Leader Dole and President Clinton have stated that this proposal has their support. While some details still have to be finalized, the proposal as passed by the governors is attached.

Background: Annual Medicaid growth has been well over 10 percent over the last decade and approached 20 percent in five of those years. As a share of state spending, Medicaid has increased from 10.2 percent to 19.4 over the 1987-1994 period.

In contrast, spending for Elementary/Secondary Education, Higher Education, Welfare, and Transportation has fallen as a percentages of state spending over the same period. Among the reasons for this dramatic increase are congressional program expansions, court decisions, and changing demographics.

Staff Contact: Dr. J.T. Young, 224-2946

RESTRUCTURING MEDICAID

PREAMBLE

For most of the last decade, health care expenditures in the United States have far exceeded overall growth in the U.S. economy. And while medical inflation is declining, public and privately funded health care costs continue to limit the long term economic growth of the nation. For states, the primary impact of health care costs on state budgets has been in the Medicaid program. Annual Medicaid growth over the last decade has been well in excess of 10 percent, and in half of those years annual growth approached 20 percent. Determining the causes of such unbridled growth is difficult. However, major contributing factors include: congressional expansions in the program, court decisions limiting the states in their ability to control costs, policy decisions by states maximizing federal financing of previously state-funded health care programs, and changing demographics.

Restricting the growth of Medicaid is no easy task. Medicaid is the primary source of health care for low income pregnant women and children, persons with disabilities, and the elderly. This year, states and the federal government combined will spend more than $140 billion in this program providing care to more than 28 million people. The challenge for the nation, and Governors as the stewards of this program, is to redesign Medicaid so that health care costs are more effectively contained and those that truly need health care coverage continue to gain access to that care while giving states the needed flexibility to maximize the use of these limited health care dollars to most effectively meet the needs of low income individuals.

THE NEW PROGRAM

Within the balanced budget debate, a number of alternatives to the existing Medicaid program have been proposed. The following outlines the nation's Governors proposal that blends the best aspects of the current program with congressional and administration alternatives toward achieving a streamlined and state-flexible health care system that guarantees health care to our most needy citizens.

Program Goals. The program is guided by four primary goals.

1. *The basic health care needs of the nation's most vulnerable populations must be guaranteed.*
2. *The growth in health care expenditures must be brought under control.*

3. *States must have maximum flexibility in the design and implementation of cost-effective systems of care.*
4. *States must be protected from unanticipated program costs resulting from economic fluctuations in the business cycle, changing demographics, and natural disasters.*

Eligibility. *Coverage remains guaranteed for:*

- *Pregnant women to 133 percent of poverty.*
- *Children to age 6 to 133 percent of poverty.*
- *Children age 6 through 12 to 100 percent of poverty.*
- *The elderly who meet SSI income and resource standards.*
- *Persons with disabilities as defined by the state in their state plan. States will have a funds set-aside requirement equal to 90 percent of the percentage of total medical assistance funds paid in FY 1995 for persons with disabilities.*
- *Medicare cost sharing for Qualified Medicare Beneficiaries.*
- *Either:*
  - *Individuals or families who meet current AFDC income and resource standards (states with income standards higher than the national average may lower those standards to the national average); or*
  - *States can run a single eligibility system for individuals who are eligible for a new welfare program as defined by the state.*

Consistent with the statute, adequacy of the state plan will be determined by the Secretary of HHS. The Secretary should have a time certain to act.

Coverage remains optional for:

- *All other optional groups in the current Medicaid program.*
- *Other individuals or families as defined by the state but below 275 percent of poverty.*

Benefits

- *The following benefits remain guaranteed for the guaranteed populations only.*
  - *Inpatient and outpatient hospital services, physician services, prenatal care, nursing facility services, home health care, family planning services and supplies, laboratory and x-ray services, pediatric and family nurse practitioner services, nurse midwife services, and Early and Periodic Screening, Diagnosis and Treatment Services. (The*

"T" in EPSDT is redefined so that a state need not cover all Medicaid optional services for children.)

- *At a minimum, all other benefits defined as optional under the current Medicaid program would remain optional and long term care options significantly broadened.*
- *States have complete flexibility in defining amount, duration, and scope of services.*

Private Right of Action

- *The following are the only rights of action for individuals or classes for eligibility. All of these features will be designed to prevent states from having to defend against an individual's suit on benefits in federal court.*
  - *Before taking action in the state courts, the individual must follow a state administrative appeals process.*
  - *States must offer individuals or classes a private right of action in the state courts as a condition of participation in the program.*
  - *Following action in the state courts, an individual or class could petition the U.S. Supreme Court.*
  - *Independent of any state judicial remedy, the Secretary of HHS could bring action in the federal courts on behalf of individuals or classes but not for providers or health plans.*
- *There should be no private right of action for providers or health plans.*

Service Delivery

- *States must be able to use all available health care delivery systems for these populations without any special permission from the federal government.*
- *States must not have federally imposed limits on the number of beneficiaries who may be enrolled in any network.*

Provider Standards and Reimbursements

- *States must have complete authority to set all health plan and provider reimbursement rates without interference from the federal government or threat of legal action of the provider or plan.*
- *The Boren amendment and other Boren-like statutory provisions must be repealed.*
- *"One hundred percent reasonable cost reimbursement" must be phased out over a two year period for federally qualified health centers and rural health clinics.*

- *States must be able to set their own health plan and provider qualifications standards and be unburdened from any federal minimum qualification standards such as those currently set for obstetricians and pediatricians.*
- *For the purpose of the Qualified Medicare Beneficiaries program, the states may pay the Medicaid rate in lieu of the Medicare rate.*

Nursing Home Reforms

- *States will abide by the OBRA '87 standards for nursing homes.*
- *States will have the flexibility to determine enforcement strategies for nursing home standards and will include them in their state plan.*

Plan Administration

- *States must be unburdened from the heavy hand of oversight by the Health Care Financing Administration.*
- *The plan and plan amendment process must be streamlined to remove HCFA micromanagement of state programs.*
- *Oversight of state activities by the Secretary must be streamlined to assure that federal intervention occurs only when a state fails to comply substantially with federal statutes or its own plan.*
- *HCFA can only impose disallowances that are commensurate with the size of the violation.*
- *This program should be written under a new title of the Social Security Act.*

Provider Taxes and Donations

- *Current provider tax and donation restrictions in federal statutes would be repealed.*
- *Current and pending state disputes with HHS over provider taxes would be discontinued.*

Financing. Each state will have a maximum federal allocation that provides the state with the financial capacity to cover Medicaid enrollees. The allocation is available only if the state puts up a matching percentage (methodology to be defined). The allocation is the sum of four factors: base allocation, growth, special grants (special grants have no state matching requirement) and an insurance umbrella, described as follows:

1. *Base. In determining base expenditures, a state may choose from the following—1993 expenditures, 1994 expenditures, or 1995 expenditures. Some states may require special provisions to correct for anomalies in their base year expenditures.*
2. *Growth. This is a formula that accounts for estimated changes in the state's caseload (both overall growth and case mix) and an inflation factor. The details of this formula are to be determined. This formula is calculated each year for the following year based on the best available data.*
3. *Special Grants. Special grant funds will be made available for certain states to cover illegal aliens and for certain states to assist Indian Health Service and related facilities in the provision of health care to Native Americans. States will have no matching requirement to gain access to these federal funds.*
4. *The Insurance Umbrella. This insurance umbrella is designed to ensure that states will get access to additional funds for certain populations if, because of unanticipated consequences, the growth factor fails to accurately estimate the growth in the population. Funds are guaranteed on a per-beneficiary basis for those described below who were not included in the estimates of the base and the growth. These funds are an entitlement to states and not subject to annual appropriations.*

   Populations and Benefits. Access to the insurance umbrella is available to cover the cost of care for both guaranteed and optional benefits. The umbrella covers all guaranteed populations and the optional portion of two groups—persons with disabilities and the elderly.

   Access to the Insurance Umbrella. The insurance umbrella is available to a state only after the following conditions are met.

   1. *States must have used up other available base and growth funds that had not been used because the estimated population in the growth and base was greater than the actual population served.*
   2. *Appropriate provisions will be established to ensure that states do not have access to the umbrella funds unless there is a demonstrable need.*
5. *Matching Percentage. With the exception of the special grants, states must share in the cost of the program. A state's matching contribution in the program will not exceed 40 percent.*
6. *Disproportionate Share Hospital Program. Current disproportionate share hospital spending will be included in the base. DSH funds must be spent on health care for*

low income people. A state will not receive growth on DSH if these funds constitute more than 12 percent of total program expenditures.

Provision for Territories. *The National Governors' Association strongly encourages Congress to work with the Governors of Puerto Rico, Guam, and other territories towards allocating equitable federal funding for their medical assistance programs.*